Maxillofacial Trauma Answer Sheet

Name: _____ Rank/Grade: _____

Duty Location: _____ DSN: _____

Your Mailing Address: _____

_____

_____

Provide your answers below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

Please read the following, sign, and date:

I affirm that these answers are the result of my work alone and that I have not received assistance from others.

_____ _____

(Signature) (Date)

Mail ONLY THIS SHEET or fax it [DSN: 792-7667 or commercial (847) 688-7667] to DIS at:

USAF Dental Investigation Service
Detachment 1, USAFSAM
310C B Street, Bldg 1H
Great Lakes, IL 60088-5259